OFFICIAL ACTIONS

Position Statement on *Crisis in Child Mental Health: Challenge for the 1970's*, the Final Report of the Joint Commission on Mental Health of Children

This statement was approved by the Board of Trustees of the American Psychiatric Association on December 12, 1969, upon recommendation of the Association's Task Force on the Report of the Joint Commission on Mental Health of Children, comprised of: J. Cotter Hirschberg, M. D., Stanislaus Szurek, M. D., Milton E. Senn, M. D., Kent Zimmerman, M. D., Exie Welsch, M. D., Richard S. Ward, M. D., Walter E. Barton, M. D., and Robert L. Robinson, ex officio.

The trustees have requested the task force to continue its work of studying and recommending positions on the technical reports of the Joint Commission as necessary, and also to advise on implementation of the Joint Commission's recommendations.

Foreword

The final report of the Joint Commission on Mental Health of Children is vast in scope and detail. Its many recommendations, reaching into all areas of national life, do not lend themselves to blanket endorsement. They call for extensive study, adaptation, and modification to accord with political, social, and economic realities in the long-range process of implementation. In the course of that process in the years ahead, the Association will be called upon to adopt many "positions" on specific proposals of the Commission. But there is, we believe, an obligation on the part of the Association to offer an initial reaction to the report and some extended commentary about its findings and recommendations by way of suggesting a stance of organized psychiatry with which it is hoped the overwhelming majority of psychiatrists will agree.

The following commentary is offered in that context. It is largely based on the findings of a task force appointed in 1968 to formulate a position statement on the Commission's final report for consideration by the trustees. The trustees are most grateful to the task force for its assistance.

Approval and Commendation

The trustees hereby record their enthusiastic approval and support of the spirit and principles underlying the findings of the Joint Commission on Mental Health of Children. The Association may be prideful that it was instrumental in initiating the Commission in 1965. We wish to express our gratitude and congratulations to all who made possible so great an achievement, and most especially to Senator Abraham Ribicoff, who spearheaded the authorizing legislation in the Congress, to the many allied organizations and agencies that participated, to the officers and staff of the Commission, and to the hundreds of professionals and concerned citizens from our own and cooperating disciplines who gave to the effort so much of their knowledge and time.

It is the intent of the Commission in its final report to alert the nation to its past failures in meeting the needs of young people from birth to adulthood, the price that we are paying and must pay for our failure, and the promise that lies in remedying that neglect. It pleads for a new kind of society, a child-respecting society, and it projects a comprehensive blueprint for structuring it. In the new society there will be three priorities of equal emphasis: 1) the provision of comprehensive services to ensure the maintenance of the health and mental health of all children and youth; 2) the provision of all needed remedial services for all children in trouble—the mentally ill, the delinquent, the mentally retarded, and other handicapped children and youth; and 3) the establishment of a highly structured advocacy system at every level of government to ensure that the first two goals are in fact realized and sustained.

In our view the Commission's program is thoroughly in accord with the American tradition and, in our affluent society, is economically

feasible. If such a program were to capture the imagination of the American people and their leaders, its gradual implementation would bring about desperately needed changes in the quality of American life and would, in due time, vastly strengthen the nation's resolve and capacity to deal with its awesome problems. Adoption of the goals and the intent of the recommendations would, in the Commission's own words, "rekindle the spirit of generosity, of magnanimity, of neighborliness, of gentleness and compassion, and of zest and adventure that are part of the American heritage."

Specific Commentary and Interpretation

Some Matters of Emphasis

It is important that the psychiatrist reader understand that the final report goes far beyond an assessment of the clinical needs of the mentally ill and retarded children and youth. Indeed, while the report pledges equal priority to social, economic, and educational measures to promote mental health on the one hand, and to remedial measures to meet the clinical needs of the mentally ill on the other, by far the greater portion of the text is devoted to the former.

The fact that so many experts from so many disciplines were able to agree on the Commission's comprehensive and innovative program for the nation is, of course, one of the report's outstanding virtues and imparts to it a quality of great historical significance.

Nevertheless, the trustees feel compelled to point out that had the work of the Commission and its final report been closely focused around the psychiatrist's view of the needs of the child, the relative emphasis on preventive and remedial needs would have been more balanced. While the clinician's view of the needs of the emotionally ill child is adequately and even admirably stated in parts of the report, it is by no means highlighted. Nor have the lengthy sections dealing with environmental reform been properly conceptualized to relate to the clinician's view of the child's needs in various stages of development.

Because they are not sufficiently highlighted in the report, we urge upon all concerned with carrying out the Commission's program that the following general considerations are by far the most critical ones in planning comprehensive health services for children aged one to five.

Provision for identification, comprehensive diagnosis, and treatment of childhood mental disorders is, indeed, of equal importance with provisions for prevention and the promotion of mental health.

There is telling need and promise of extremely productive results in improving our presently inadequate medical services to the child in his first five years of life, especially by providing family planning services, sound prenatal care, improved obstetrical management, and comprehensive pediatric services. In the age range one to five it is the general physician, the obstetrician, the pediatrician, and the child psychiatrist who can play the most telling roles in providing these services.

Well-baby clinics have been the principal agency to serve mother and child after birth. But in general they are of service only during the first year of life and, in the main, are primarily limited to pediatric assistance. Also, our day care centers, as presently conceived, are inadequate to meet the needs of children under five because of their relative divorcement from the interplay of child and family. A new mechanism, a new "thing," something that might be titled "child and family development center," is needed to ensure the availability of comprehensive health services, including not only pediatric care but also genetic counseling, child neurology, child psychiatry, obstetrics, gynecology, and related services.

We also urge—as the Commission has not—that the newly developing community mental health centers be viewed as a major potential resource for the delivery of services to children. Indeed, we believe that provision for such services should be specifically added to the present five requirements of community mental health centers in their regulations governing federal funding of such centers.

In projecting the kinds of needs that must be met in a total network and continuum of services, we would have them structured around the following headings:

1. Services to normal children and normal families concerned with developmental and situational tasks. These services are both preventive and actual and include such community resources as pre- and post-natal health services, well-baby clinics, day nurseries, preschool programs, family and children's agencies, public health nursing, and other public health services.

2. Services to normal children with problems in growth and development, which would not require specialized psychiatric help but could be handled by such community resources as the family physician or pediatrician, school health clinics, recreational services, vocational services, and the community resources offered within many church-related activities.

3. Services to families in trouble.

4. Services to children who demonstrate a need for early intervention for minor emotional disturbances of an order that can be handled by psychologically and educationally aware agencies and educational programs and remedial services.

5. Services to emotionally disturbed children

who need specialized psychiatric treatment but who are still able to reside in their own families and their own communities. Such services would include special educational programs in the schools, pediatric-psychiatric outpatient services, community mental health clinics, therapeutic nursery schools, group casework and group psychotherapy, and therapy for parents and families.

6. Services for emotionally disturbed children who need placement away from their families either because of their own degree of emotional illness or because of disrupted family structure, but children who are still able to function within their own communities. Such services would entail foster care, boarding families, adoptive homes, group homes, and community youth centers.

7. Services to children with severe emotional illness requiring hospitalization in residential treatment centers, or inpatient psychiatric centers, or children's psychiatric hospitals for treatment and rehabilitation to facilitate their early return to family and community. Such services may be provided in a general hospital, in a community mental health center, or a specialized psychiatric hospital for children followed by aftercare and rehabilitation. Child psychiatric hospital care must be upgraded to ensure adequate staffing and treatment programs, the provision of proper schooling and vocational rehabilitation, as well as concomitant casework with the parents and often with the entire family.

With reference to state hospital care for emotionally ill children, the Commission has been justified in noting the grave inadequacies of state hospital facilities. Such facilities, however, if adequately staffed and programmed, can provide an essential service for some severely ill children. They should not be perceived as "end of the road" institutions. It is gratifying that the Commission has indicated its favorable disposition to the American Psychiatric Association's recommendations regarding state hospital care for children issued in 1964(1).

The above points are made not so much by way of taking exception to the Commission's findings but rather by way of pointing up the medical view of the most *essential* elements to be incorporated initially into a national program for children and youth. As the program unfolds it must be the purpose of psychiatrists to urge these points of view upon the myriad of planning groups that will be involved, and particularly upon the neighborhood child development councils. If they are to guarantee comprehensive health services for every child, then they must fully grasp what the needs actually are. Further, they must understand that the one-to-five age period is the period of most vital need for health services. The report appears to convey the overall impression that after age three the child's needs can be met primarily through educational services.

Be that as it may, psychiatrists generally will be able to lend their unqualified endorsement to what the final report does say about the emotionally disturbed and mentally ill children in our country. The poverty of our present resources and methods for treating the emotionally ill child is not exaggerated by the Commission and adds up to an appalling reflection of the nation's past indifference and neglect of these children. The Commission makes a strong and convincing plea for the reorganization of our entire system of remedial services into an effective network and continuum of services that will indeed meet the needs of every ill child in relation to his stage of development. Again, it is gratifying that the Commission, in this regard, quotes approvingly from the American Psychiatric Association's report on *Planning Psychiatric Services for Children*(1).

Moreover, psychiatrists will generally applaud the report's treatment of the school as part of the developmental process. Indeed, the report's general approach to the impact of contemporary American society on growth and development opens up a very wide range of collaborative roles for psychiatrists and child psychiatrists in the unfolding of the program. To be sure, these roles are not spelled out, and in some measure the report reflects doubts about reliance on the medical model as the matrix around which to construct a system for the identification, diagnosis, and treatment of the mentally ill child. Nevertheless, the report does not gainsay and indeed implicitly accepts the reality that the clinical psychiatrist is uniquely qualified to give leadership in integrating the multiple input of many disciplines in assessing the total needs of the child; the psychiatrist's role in the implementation of the program can be rationally projected only in that context.

The Advocacy System

The basic theme of the final report is to "urge the creation of a network of comprehensive, systematic services, programs, and policies which will insure every American the opportunity to develop his maximum potential. Such a network would interrelate all those services and institutions which affect the lives of our young. The line between the preventive and remedial nature of services would be blurred by designing and coordinating services to meet the developmental needs of the total child." The statement will meet with the general approval of our profession.

To achieve the goal, the Joint Commission

would interpose an "advocacy system" cutting across every level of the American body politic—national, state, and local.

Briefly, at the top of the advocacy structure there would be a President's Advisory Council on Children, endowed with the power and prestige of the President's office in relation to his Cabinet, the Congress, the Bureau of the Budget, and more than a score of federal agencies involved in one way or another with programs for children and youth. To reinforce the Advisory Council a strong staff unit would be created in the Department of Health, Education, and Welfare.

Counterpart child development agencies with staffs would be established by state governments with the crucial mission of developing comprehensive state plans for securing the range of services envisaged as essential by the Commission.

At the city-county level of government, local child development authorities would be created to serve as coordinating, planning, and policy setting bodies for the range of services required in its jurisdiction.

At the neighborhood level the Commission recommends the establishment of child development councils throughout the nation whose primary function would be to act as direct advocates for every child in the community they serve. To them would fall the responsibility and prerogative of ensuring that complete diagnostic treatment and preventive services are available to all children in the neighborhood. The councils would comprise the foundation of the advocacy system. Under their aegis, it is hypothesized, no child would be lost in a bureaucratic morass and no child in need would be shunted from one agency to another, receiving little help from any. The council structure would guarantee the availability of services.

In the Commission's view, only by superimposing such a child-oriented advocate structure can we hope to bring some semblance of order out of the system (or nonsystem) of fragmented services that now obtains. Only thus can we expect to rally sufficient support at the grass roots of the body politic to plan for and eventually provide the essential range of services required. The Commission emphasizes, quite correctly, that the advocacy structure at all levels would *not* be responsible for providing direct services, but rather only with planning, coordinating, facilitating, and guaranteeing that such services shall be available. The work of the councils would be financed by federal and state funds.

The trustees believe that the advocacy structure as recommended by the Commission is basically rational, sound, sensible, and feasible. Such a concept will find precedent in community involvement, for example, in planning community hospitals under the Hill-Burton program, and in the federally financed comprehensive state community mental health planning of recent years. Moreover, we quite agree with the Commission on emphasizing the advocacy function of the councils at every level as distinguished from administrative responsibility for financing and operating direct services. We further agree with the Commission's suggestions as to how to proceed to institute the advocacy system beginning with the President's Advisory Council on Children, namely:

First, the creation of the President's Advisory Council.

Second, the establishment of state child development agencies in each state, and the initiation of comprehensive planning (federally financed).

Third, the establishment of at least one local child development authority in each state.

Fourth, the establishment of as many as 100 child development councils, with at least one in each state.

Fifth, the creation of about ten evaluation centers in representative communities to study, test, and evaluate the goals proposed for the councils and thereby lay the groundwork for ultimately spreading the council structure to the point that no child in America grows up in a community without one.

Manifestly, such an elaborate structure will take many years to build, and it would be fruitless to attempt a beginning except at the White House level. The trustees urge upon the President of the United States that he give immediate attention to the proposal and the need to establish the Advisory Council at the national level as a starting point to initiate the advocacy structure. The trustees will further urge upon the President that at least two members of the proposed Advisory Council should be physicians selected from those specialties most concerned with the health and mental health of children from age one to five, especially from the ranks of psychiatry, obstetrics, and pediatrics. Indeed, we shall urge such appropriate professional representation on the councils and staffs of the entire advocacy structure so far as is feasible.

Manpower and Training

That section of the final report that deals with the human resources needed to structure a child-oriented society is altogether farsighted and innovative. In being innovative the recommendations are also controversial, but this is all to the good by way of stimulating fresh thinking and quickening action to overcome manpower and womanpower shortages and to improve the utilization and distribution of manpower in the field.

To begin with, the Commission quite properly asks for the creation of a federal manpower policy to come to grips with the need for staffing the entire advocacy system, a policy that will accommodate a vast expansion of federally supported training facilities and personnel and the financing thereof. There is nothing impracticable about the proposal. It will be incumbent on the President's Advisory Council on Child Development to ensure that an adequate staff is employed to carry out the research and planning that must underlie the development of the policy. The trustees fully support this proposition and, with some qualifications, all of the basic recommendations of the final report on how this nation can develop the manpower needed to carry out the implementation of the advocacy system.

For example, it is recommended that the National Institute of Mental Health should allocate a minimum of 50 percent of its training funds to the education of specialists in work with children and youth. The repercussions of such an arbitrary ruling, if it were to be made, would have no small impact on psychiatric education today, not to mention the other disciplines. Nevertheless, the figure 50 percent is certainly not exaggerated in relation to the need. The trustees urge NIMH to give serious consideration to the extent to which the recommendation could be feasibly entertained in relation to other priorities at the present time.

The trustees are also favorably disposed toward many of the other specific recommendations of the Joint Commission in the manpower field, notably that recipients of federal training grants should agree to serve for a reasonable period in child and adolescent mental health work; that the federal government should undertake tax incentives as an instrument to encourage mental health professionals to work in areas that are receiving few or no services; that a national service program could be launched to allow young people to participate in service activities in deprived areas such as ghettos, Appalachia, etc.

Further, we approve the recommendations pertaining to clinical training of child care workers to meet the need of the child in the first five years of life, and the need to have such training carried out in clinical settings. We would emphasize that these settings must be adequately financed if they are to do the job adequately. In general, it is one of the unique contributions of the report as a whole that it emphasizes "growth and development" as a basic science in the field of human behavior and demonstrates its vital relevance to the teaching and training of all professionals and paraprofessionals. Clearly, clinical psychiatrists have an immense responsibility in the clinical training of all of the professions serving children.

All in all, the Commission's recommendations proposing the rapid development of paraprofessionals are to be applauded. We agree in principle with the need for a new hierarchy of careers, the restructuring of old ones, and with the concept of inventing a "career ladder" that would allow child care workers to move up as they move either vertically or horizontally across the personnel structure of the field.

We do not share the Commission's seeming enthusiasm for the British model of a Doctorate in Medical Psychology. We are similarly uncertain about training a new "profession in child development" to serve as administrators of the child development councils, to supervise day care and preschool facilities, to act as child-parent counselors, and to supervise paraprofessional workers in home visit programs, etc. It is not that either concept lacks merit, but in our view they should be posed as merely examples of experimental patterns that might be tried out. It would be premature to forge full speed ahead at this time with rigid plans for producing new kinds of professionals.

Research

The trustees are fully supportive of the Commission's recommendations concerning increased support for research and with its goal of establishing a "research climate" throughout our society. Specifically, we support the proposal that ten child health research centers be established under the auspices of the National Institute of Mental Health and the National Institute of Child Health and Human Development to undertake long-range studies in such problem areas as the development of a more adequate system of nosology, diagnosis, and classification, longitudinal studies of the natural history of emotional disorders in children, childhood autism, the effects of various kinds of therapeutic intervention, and many other areas.

We are particularly pleased to note that the Commission has been farsighted enough to recommend equal support for basic and applied, including clinical, research. In our view, the latter is just as "basic" as the former. Admittedly, as the report states, it is difficult to define clinical concepts in objective, measurable terms, making clinical research more difficult and demanding than laboratory investigations. The problem is to assemble clinical data that are comparably based on comparably diagnosed patients, on comparable treatment programs, and on comparable therapists. Be that as it may, in our view the difficulties should not be allowed to discourage far more emphasis on supporting clinical research than has been given it in the past.

All in all, the Commission's findings on research are fully consonant with our view of the essentiality of preserving an eclecticism in research policy so necessary to avoid the shutting off of any promising directions of investigation. We would emphasize the relating of evaluation to applied research in the report. The need for continuous evaluation and assessment of results throughout the advocacy system will be ongoing and fundamental, and most particularly in the early demonstration projects designed to elicit the know-how to further implementation of the system.

American Society and Its Impact on Youth

The Commission's final report presents the American people with what may be appropriately called a series of analytical essays on the impact of American society on young people. They cover such topics as the interrelationships of poverty and mental health, minority groups as a special risk, education and mental health, problems in employment, public assistance, and various environmental programs. These chapters are most admirable syntheses of existing knowledge and attitudes in behavioral science concerning what a truly child-oriented society would be like. Again, it would be inappropriate for the trustees to lend a blanket endorsement to the vast range of recommendations in the areas that the Commission has projected; it will be for individual psychiatrists in their roles of "citizen advocates" to relate to these recommendations according to their own consciences. In their totality, the recommendations add up to what is tantamount to a national political platform that the majority of psychiatrists, we venture, would support over the long haul. Indeed, one may hope that the Commission's platform for a child-oriented and child respecting society will receive the earnest consideration of both of our great political parties. Generally, in the view of the trustees, it is realistic and practicable to look to the achievement of the Commission's goals by the year 2000, and many of them much sooner than that. Such achievement is essential if the causes of deterioration of our society are to be remedied and if its upward thrust toward a better life for all is to be sustained.

There are two general recommendations which the trustees would specifically endorse.

First, the Commission recommends that the Congress or the President's Advisory Council on Child Development should establish a body, a consortium, or a permanent study group comprising many who participated in the work of the Commission, and others, to impart expertise of the highest order to the gradual implementation of the advocacy system. The precise form such a body might take is not spelled out in the report, but it would serve as a highly prestigious "voice for children," and as a strategy and planning group to assist in analyzing and coping with the problems that will inevitably attend the development of the advocacy system. The proposition calls for further study, and the trustees will be pleased to cooperate with others in undertaking it.

Second, child psychiatrists, and general psychiatrists for that matter, will particularly applaud the report's emphasis on such matters as improved programs for preschool children, adoption and foster care practices, legal and probation services, homemaker services, family and premarital counseling services, and others, all of them essential from the clinician's point of view in meeting developmental needs.

Concluding Comments—Commitment to Action

Manifestly, the Commission's detailed blueprint for a new society adds up to a very large order. The Commission itself has not attempted to put a price tag on its program, but it has been estimated by some who participated in its work that a national investment in the range of six to ten billion dollars a year would be required to make it fully operable. Such sums are modest enough when viewed as the price we must pay to cope with the disaster-threatening problems of our time. Implementation of the recommendations calls for a "shift in strategy for human development" in our nation, a qualitative change in values and attitudes. Ultimately, such a program can be carried out only by eliciting the support of a very large segment of the entire body politic. A beginning must be made initially by enlisting the interest, understanding, and support of leadership groups in our society—the range of professions, social and political interest groups, federal, state, and local political administrations, and the vast array of existing public and private agencies that comprise our present "nonsystem" of services for children and youth. Professional societies such as our own will have many vital roles to play in arousing this kind of support, and the trustees pledge the American Psychiatric Association to lend all possible support to this end.

In addition to those indicated above, other initial steps that the trustees consider it appropriate for the Association to undertake are these:

1. We urge all members of the Association to read the final report of the Commission and give thoughtful consideration to what they may do both in their professional capacity and as citizens to further its objectives. (The full text of the report will be published by Harper and Row, New York City, early in 1970. In the meantime, an excellent summary of its major findings is available in pamphlet form[2], from the Joint Com-

mission on Mental Health of Children, Inc., 1700 18th St., N.W., Washington, D. C. 20009, for $1.50 a copy.)

2. The trustees will urge the following actions on the President of the United States and the Secretary of Health, Education, and Welfare: a) that they publicly acknowledge the exciting challenge to the American people presented by the Joint Commission on Mental Health of Children and commend it to further study by relevant key personnel in their administration; b) that they proceed with all feasible dispatch to convene a conference of all relevant members of the President's Cabinet and of administrative heads of federal programs serving children and youth to consider strategy and planning for inaugurating the advocacy system; c) that immediate consideration be given to the appointment of the President's Advisory Committee on Children and the establishment of a high-level supporting staff in the Department of Health, Education, and Welfare to plan for the extension of the advocacy system to states, cities, counties, and communities; d) that they use their good offices to help ensure that a significant portion of the agenda of the forthcoming White House Conference on Children and Youth shall be devoted to a consideration of the final report of the Joint Commission.

3. The trustees will similarly urge upon Senators and Representatives that they similarly express their support of the advocacy program and that they initiate and facilitate supportive legislation to launch it.

4. The trustees call upon the APA Commission on the Delivery of Mental Health Services and the APA Committee on Financing of Mental Health Care to scrutinize carefully the range of health and mental health services for young people as put forth by the Commission and attempt to propose a suitable delivery service system and the financing thereof to assure their realization. The attention of the Commission is particularly invited to the report's failure to define the potential role of the community mental health center in future delivery systems. Indeed, very little is said about these centers other than to note that they have thus far failed to provide significant services for children. It appears to the trustees that the role of these centers could be rendered far more effective if they were adequately funded and staffed. We would add the comment that, in general, the report performs a magnificent service in itemizing the kinds of services that are needed. It fails, however, to delineate the institutions and modalities through which they can be delivered. The Commission and the Committee could contribute much to remedying the deficiency.

5. The trustees will call upon the Association's district branches and their appropriate councils, committees, and task forces to review the report from the vantage point of their own interest fields and to make such recommendations as they may wish as to how the Association can exercise a telling influence in furthering the advocacy program.

6. The trustees will explore and cooperate with other concerned national associations and agencies regarding what steps may be taken together by way of convening conferences of professional and public leaders to consider the implications of the final report's major recommendations and what steps may be taken, and in what sequence, to further their implementation. We have in mind especially the American Medical Association, the National Association for Mental Health, the Council of State Governments, and member and affiliate organizations of the Joint Commission on Mental Health of Children. The trustees will also call the attention of the Association of American Medical Colleges to the implications of the report for curriculum planning.

7. In general, as interest in and understanding of the Commission's program grows, the trustees will be prepared to entertain proposals for cooperative action to implement it from all appropriate sources.

REFERENCES

1. American Psychiatric Association: Planning Psychiatric Services for Children, Washington, D. C., 1964.
2. Joint Commission on Mental Health of Children, Inc.: Digest of Crisis in Child Mental Health: Challenge for the 1970's, Washington, D.C., 1969.